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	HFD12-0072	A. BUILDING _____ B. WING _____	11/25/2008

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I 000	INITIAL COMMENTS A monitoring survey was conducted on November 25, 2008. The findings identified in the May 29, 2008 annual licensure Statement of Deficiency report served as the focus for this monitoring survey. The facility was providing services and supports for four men with various disabilities. One of the original two sampled residents was reviewed, with a second, new resident added. In addition, a focused review was conducted of the behavior support needs for a third resident. The findings of this survey were based on observations, interviews with administrative and direct support staff in the home, as well as a review of resident and administrative records, including incident reports.	I 000	Received 12/29/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on observations, interview and review of staff training records, the GHMRP failed to ensure sanitary food handling and storage practices. The finding includes: On November 25, 2008, at 10:54 AM a frozen turkey was observed on the counter in the kitchen. At 12:44 PM, the frozen turkey remained on the kitchen counter. A staff was observed putting the turkey in the refrigerator at 1:10 PM.	I 056	All Staffs were in-serviced on how to defrost/thaw frozen foods on 12/ /08. In the future all frozen food will be defrosted in the refrigerator or under a running tab.	

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I 056	Continued From page 1 Interview with the residential manager at 4:37 PM revealed the staff had been trained on proper techniques for defrosting meats. There was no evidence, however, that the facility monitored its food handling procedures to ensure they were effectively implemented to prevent potential growth of food-borne organisms.	I 056	All staffs were in-serviced on proper techniques for defrosting meals on 11/27/08. In the future the RTL will monitor the staff for proper defrosting and thawing of frozen foods.	
I 077	3503.5 BEDROOMS AND BATHROOMS Each bedroom shall contain sufficient storage space for each resident's seasonal, personal clothing and personal effects. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure bedrooms contained sufficient storage space for the seasonal clothing of one of the two residents in the sample. (Resident #1) The finding includes: Observation of Resident #1's bedroom on November 25, 2008, at 9:50 AM, revealed folded outer clothing stored on top of his wardrobe. Further observation revealed pairs of shoes on the floor, set openly beside the recliner. Interview with the Residential Team Leader indicated that the resident's shoes were sometimes stored in the wardrobe; however, it was full of clothing and other personal effects. There was no evidence that the chest and wardrobe in the resident's bedroom provided adequate storage space for his personal belongings.	I 077	All clothing were folded and stored on top of the drawer was removed on 11/25/08. All clothing for Resident # 1 was sorted according to season and stored appropriately according to season. In the future all clothing will be sorted according to the appropriate season and stored accordingly.	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be	I 090		

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I 090	Continued From page 2 maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner. The finding includes: On November 25, 2008, a walk through of the facility was conducted with the Residential Team Leader (RTL), beginning at approximately 10:00 AM that revealed the following: 1. There was an accumulation of dust on the ceiling fans located throughout the facility, including the three bedrooms and the living room. 2. Screws were loose in the right armrest of a chair at the dining room table. When pressure was applied, the armrest moved about. 3. At 11:28 AM, a section of the wall paneling in the kitchen, to the right side of the sliding glass door was observed to be loose. 4. At 10:20 AM, the ceiling fan located in Resident #2's bedroom was observed to not adequately be secured to the ceiling. One side of the base was loose, hanging downward from the ceiling. At 10:28 AM, the ceiling fan in Residents #3 and #4's bedroom were also observed to be not tightly secured to the ceiling on one side. 5. At approximately 10:37 AM, the leather	I 090	1. All dust was clean on the ceiling fans located throughout the facility as of 11/26/08. All staffs were in-serviced on proper cleaning on 11/27/08. 2. The loose screws on dinning chairs were tighten on 11/28/08. 3. The loose wall paneling in the kitchen to the right of the sliding glass door was repair on 12/22/08. 4. The Ceiling Fan in Resident # 2 bedroom was secured on 12/22/08. 5. The Leather Recliner Chair in the living has been discarded on 11/27/08.	

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I 090	Continued From page 3 recliner in the living room was observed with two large tears (approximately 11 in. and 8 in. in length) that formed an X-shaped cut in the seat area. At 5:08 PM, when asked about the chair, the Program Coordinator/Qualified Mental Retardation Professional stated that she could not recall what the facility had written in the Plan of Correction (POC) submitted after the previous survey. She then asked the RTL about the status; he indicated that the chair would be replaced the next day. This is a repeat deficiency. ********** Previously, the May 29, 2008 Licensure Report included the following: "3. The leather recliner in the living room was ripped and torn."	I 090	The Leather Recliner Chair in the Living Room has been discarded on 11/27/08.	
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that a supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The findings include: On November 25, 2008, beginning at 12:43 PM, interview with the facility's personnel office	I 203		

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I 203	Continued From page 4 representative revealed that supervisors were expected to review job descriptions with each employee at least once every 12 months. After said review, the employee was to sign and date their written job description form. She further elaborated that she had established a spread sheet on which she could track the dates of each employee's job description reviews, as well as the status of trainings, certifications and other personnel-related issues. At 12:55 PM, review of the personnel records that she presented revealed no evidence that a supervisor had reviewed job descriptions with 2 of the 9 direct support staff within the previous 12 months. Staff #1 and Staff #2 had signed and dated their forms on June 7, 2007 and June 5, 2007, respectively. The personnel office representative stated that she had "missed" Staff #1. She then said she had previously sent a letter to Staff #2 informing him that he was in need of the review. At approximately 1:00 PM, she informed the Residential Team Leader (RTL) that he needed to review job descriptions with the two staff identified. [Note: At approximately 4:53 PM, the RTL was asked about job description reviews with the two employees. He said he had reviewed job descriptions with both Staff #1 and #2. Further interview, however, revealed that he could not recall whether said reviews had occurred within the past year. He confirmed that staff were expected to sign and date their job description forms to document the date of review.] This is a repeat deficiency. **********	I 203	A copy of Staff #1 and # 2 Job description has been attached for your review.	

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I 203	Continued From page 5 Previously, the May 29, 2008 Licensure Report included the following: "Review of the personnel files conducted on 5/29/08 revealed that GHMRP failed to provide evidence of a current signed job description for one direct care staff (AN)."	I 203		
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on interview and record verification, the GHMRP failed to maintain the agenda for every staff in-service training session. The findings include: On November 25, 2008, review of staff in-service training records revealed sign-in sheets with the signatures of staff who attended training on October 22, 2008. There were five (5) separate signature sheets, for sessions titled: - Active Treatment, - Program Goals, - Waiver Documentation, - Medical Appointments; and, - Infection Control. Further review of the documentation, however, revealed no evidence of agendas for the five, aforementioned trainings. At approximately 6:30 PM, the Program Coordinator/Qualified Mental Retardation Professional examined the in-service records and confirmed that there were no agendas dated October 22, 2008 available for review.	I 223	All in-serviced training records have been signed by the trainer on 11/26/08 and a copy of the training agenda have been attached to the in-serviced signature sheet.	

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I 291	Continued From page 6	I 291		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each resident's record was kept current, for one of the four residents of the facility. (Resident #3) The findings include: 1. On November 25, 2008, at 3:03 PM, review of Resident #3's program book revealed a photocopy of his behavior support plan (BSP), dated September 9, 2008. The text of the BSP, however, cited behavior data for an 11-month period that ended July 2007. Moments later, another version of this same BSP was found in the front jacket of another binder (the resident's Individual Support Plan book). It was observed that a small piece of paper with the typed date "9/9/08" had been placed directly over the date "8/16/07," which was the date originally typed on the BSP. This small piece of paper (with the more-recent date) had been secured with transparent tape. There was a faint line visible above the date on the altered document (the photocopied BSP in the program book). The faint line corresponded exactly with one edge of the tape used to secure the piece of paper with the new date. There were no other discernable differences between the two documents. At approximately 3:07 PM, Resident #3's August 2007 BSP (with the new date taped onto it) was shown to the Program Coordinator/Qualified Mental Retardation Professional (QMRP). She immediately asked "Who did that? That is	I 291	A copy of the Behavior Support Plan for Resident #3 has been attached for your review.	

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I 291	Continued From page 7 unacceptable!" Neither she nor the Residential Team Leader, who was working nearby, answered when they were asked if they knew who had altered the date. Further interview with the QMRP revealed that the facility's psychologist had left the agency "in early 2008." 2. Cross-refer to I374. According to an incident report dated September 17, 2008, Resident #3 displayed a targeted behavior (hitting himself on his head) during the morning shift. He was riding in the van to day program and the behavior resulted in his sustaining injuries (i.e. small cut, bruising and swelling) near his eye. On November 25, 2008, at 3:15 PM, review of the resident's behavior data sheets revealed that staff on the morning shift (12:00 AM - 10:00 AM) had been documenting daily behavioral observations. For example, they wrote "none" on the mornings of September 15 and 20, 2008. However, on September 17, 2008, the date of the incident, someone drew a short, horizontal line in the corresponding space. [Note: Similar lines were noted in the morning shift's behavior data on September 18 and 21, 2008.] Staff had not documented the September 17, 2008 behavioral episode, in accordance with the resident's behavior program; therefore, the data sheets failed to reflect the resident's current status.	I 291	The Program Coordinator/QMRP could not ascertain the origin of the altered document. In the future all assessment/reports have been requested to be sent directly to the Head Office and a copy will be forwarded electronically to ensure it is authentic The electronic copy will be filed in the Resident's electronic charts and a hard copy placed at the home 2. All staffs have been in-serviced on the behavior data collection on Resident # 3 behavior data. 12/24/08	
I 292	3514.3 RESIDENT RECORDS Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol.). This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to maintain resident records in accordance with requirements of D.C. Law 2-137	I 292		

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I 292	Continued From page 8 (now Title 7, Chapter 13), for one of the four residents of the facility. (Resident #3) The finding includes: Title 7, Chapter 13; D.C. Code 7-1305.12 (formerly 6-1972) Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (13) "A description of any extraordinary incident or accident in the facility involving the customer, to be entered by a staff member noting personal knowledge of the incident or accident or other source of information, including any reports of investigations of customer's mistreatment." Cross-refer to I374 and I500.3. Resident #3 reportedly sustained a self-inflicted cut, bruising and swelling to his right eye area on September 17, 2008. Staff reported that the injuries occurred while riding in the van, at approximately 7:45 AM. Interview with the RN on November 25, 2008 revealed that he had directed staff to take Resident #3 to the ER shortly after 5:00 PM that evening. The RN also stated that it was the agency's practice to automatically send residents to the ER "if anyone hits their head and there's an injury. . That's what we have do..." Staff had not, however, notified the RN timely and Resident #3 had not been automatically taken to an ER for evaluation. On November 25, 2008, at 3:17 PM, a request was made to see the original incident report and corresponding investigation. However, the Program Coordinator/Qualified Mental	I 292	Staffs have been in-serviced on Incident reporting on 12/24/08. In the future all incidents will be reported to the Nurse timely.	

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I 292	Continued From page 9 Retardation Professional (QMRP) stated that the documents requested were not kept in the facility. As an agency-wide practice, they were not to include the incident reports or corresponding investigations in the residents' records. After the QMRP spoke with their Incident Management Coordinator (IMC) via telephone, she stated that she would forward the documentation to the Health Regulation Administration via facsimile as soon as the IMC made them available. No additional information was presented before the monitoring visit ended that evening, at 7:20 PM. On November 28, 2008 (post-survey), the facility forwarded some materials via fax transmittal. However, neither the incident report nor the corresponding investigation report was included. As of the close of business December 2, 2008, the requested reports had not been made available for review. In addition, there was no documented evidence that the above-referenced incident had been investigated by the facility's IMC.	I 292	The QMRP requested the Incident Management Coordinator to fax the requested documents to DOH. The QMRP was informed the requested documents had been faxed to DOH. In the future any documents requested from the QMRP will be faxed by the QMRP herself and a call made to DOH to ensure the faxed documents were received and ensure further proper follow-up.	
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of the resident's legal guardian of significant incidents, for the sole resident who	I 374		

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I 374	Continued From page 10 had sustained an injury since the May 29, 2008 survey. (Resident #3) The finding includes: On November 24, 2008, a pre-survey review of the Health Regulation Administration (HRA) incident database revealed that on September 18, 2008, the facility had submitted a written report that documented an incident from the previous day. Resident #3 reportedly sustained a self-inflicted head injury during a behavioral episode while being transported in the community. Resident #3's psychological and nursing records were reviewed in the facility on November 25, 2008, beginning at approximately 3:03 PM. His behavior support plan (BSP), dated September 9, 2008, identified slapping his own head as one of his targeted maladaptive behaviors. A Monthly Nursing Summary, dated October 14, 2008, documented "ER visit due to head injuries sustained in the van when going to day program on September 17, 2008." Nursing progress notes from September 17, 2008 also documented the injury and trip to the ER. At 3:17 PM, a request was made to see the original incident report and corresponding investigation. However, the Program Coordinator/Qualified Mental Retardation Professional (QMRP) stated that the documents requested were not kept in the facility, as per agency policies. After she spoke with their Incident Management Coordinator (IMC) via telephone, she stated that she would forward the documentation to HRA via facsimile as soon as the IMC made them available.	I 374	The Limited Medical Guardian was notified by the Program Coordinator/ QMRP on September 18, 2009. In the future all notification will be made before Incident Report is faxed to DOH and all concern parties to ensure all concern is aware of every person notified.	

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I 374	Continued From page 11 At 4:34 PM, review of Resident #3's Health Passport revealed that he had a court-appointed guardian. When asked, the QMRP confirmed that the man listed was the resident's "full, legal guardian." When asked if he had been notified of the head injury and resulting ER visit, the QMRP replied "Yes... If it wasn't the house manager, it was me." A moment later, the Residential Team Leader (RTL, aka house manager) was asked if Resident #3's legal guardian had been notified of the recent injury and ER visit. He replied "Either I do it or <the QMRP's name> does." When asked again about this specific incident, he replied "I think it was <the QMRP's name>." A moment later, the QMRP was asked again if she had notified the guardian. She said she recalled having left a message on the guardian's telephone answering machine. She further indicated that the date and time of the telephone message would be documented on the incident report, as per agency policy. No additional information was presented before the monitoring visit ended that evening, at 7:20 PM. On December 2, 2008, review of the incident report that was originally faxed to HRA on September 18, 2008 revealed that the house manager, LPN and IMC were notified on September 17, 2008. Additional notifications were documented for the next day; however, the resident's legal guardian was not among those listed as having been notified. [Note: A lawyer assigned for annual court reviews had been notified. The lawyer, however, was not the guardian.]	I 374	Please find attached a copy of the incident report with all notified party listed for your review. In the future, all notification will be completed before a copy of the report is faxed to DOH in order to ensure all parties are aware of those contacted. All parties were notified and noted on the report accordingly. The report was faxed to DOH before the entry for the Legal Guardian's notification was entered on the report. In the future all parties will be notify timely. The Program Coordinator/QMRP was trained on Incident notification on 12/22/08 by the Incident Management Coordinator. A copy of the training signature sheet has been attached for your review.	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis	I 401		

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I 401	Continued From page 12 and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure professional evaluation and treatment services designed to prevent deterioration of function, for one of the two residents in the sample. (Resident #1) The findings include: The GHMRP failed to ensure that physical therapy recommendations were coordinated for Resident #1. Interview with the Residential Team Leader (RTL) on November 25, 2008, at 9:55 AM, revealed that Resident #1 used a walker and required 1:1 supervision to ensure his safety during ambulation. At 12:21 PM, review of Resident #1's record revealed a physical therapy (PT) progress note dated April 9, 2008 which recommended a formal program to increase the resident's strength in his lower extremities. The progress note also indicated that the resident might benefit from an AFO (ankle-foot-orthosis) for his right foot, and that the formal assessment report would follow. At 1:35 PM, interview with the Program Coordinator/Qualified Mental Retardation Professional (QMRP) revealed that she was previously unaware of the PT's note regarding the AFO. She indicated that Resident #1's interdisciplinary team (IDT) had met for the annual review on September 7, 2008. At that	I 401	A request was made for a follow-up assessment with the Physical Therapy. An appointment for a visit and further assessment is scheduled for December 30th, 2008. In the future the Program Coordinator/ QMRP will ascertain clarification for any confusing recommendation made by the Physical Therapy in order to ensure his recommendation is carried out as ordered and timely.	

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	HFD12-0072	A. BUILDING _____ B. WING _____	11/25/2008

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I 401	Continued From page 13 time, however, she had not received the formal PT assessment. She further acknowledged that the potential use/benefit of an AFO had not been discussed with the IDT on September 7, 2008. At approximately 5:30 PM, the QMRP presented Resident #1's written PT assessment. She stated that although the assessment was dated April 9, 2008, the document had been received a few days after the annual meeting. The IDT, therefore, did not have a current PT assessment available for discussion and consideration during the September 7, 2008 meeting. According to the fax cover sheet, the assessment was received on September 11, 2008, five months after the PT had seen the resident and written the progress note about an AFO. At the time of the survey, the PT's April 2008 recommendation for an AFO had not been addressed. [Note: At 6:38 PM, the resident was observed ambulating with his walker and a direct care staff was next to him. He did not, however, have an AFO on his right ankle.]	I 401	The PT was contacted informed he wanted to re-assess Resident #1 for further clarification of the recommendation on AFO. A re-visit date of 1/6/09 is scheduled. A request was made and the PT has agreed and scheduled to re-assessed Resident # 1 on 1/6/09. Upon receipt of the assessment, the IDT will discuss the recommendations.	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of persons with	I 500		

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I 500	Continued From page 14 mental retardation. The findings include: 1. The facility failed to protect residents' rights to privacy in sleeping and personal hygiene practices [Title 7, Chapter 13, § 7-1305.05(d), formerly § 6-1965(d)], as follows: On November 25, 2008, beginning at approximately 10:00 AM, a tour of the upstairs revealed that windows in the bedrooms used by Residents #1, #3 and #4 were furnished with sheer curtains. The curtains were made of a thin material and did not ensure privacy for the residents. In daylight, surveyors were able to view the neighboring community from the bedrooms, while the curtains were drawn, to include windows of neighboring homes, cars and people passing by on the street. After dark, the viewing was reversed, where the residents were visible from the street while they and their staff were in the upstairs bedrooms. 2. The facility failed to demonstrate protection of residents' rights to be free from unnecessary or excessive medication; specifically, psychotropic medications. [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h)], as follows: a. On November 25, 2008, at approximately 3:45 PM, review of Resident #3's physician's orders (POs) revealed that they were dated November 1, 2008. There were no POs for the month of October. Further review of the resident's medical records revealed that the previous POs were dated August 1, 2008. Both the August and November POs included a hand written statement "Orders good for 90 days." Resident	I 500	A room darkening shade has been installed in the window of Resident #s 1, 3 and 4 bedroom. In the future the rights of all residents will be considered when installing fancy curtains which might not provide enough privacy. Psychotropic medications will continue to be reviewed monthly at psychotropic med reviews with renewal orders transcribed from psychotropic med review form monthly by Nursing. Staff training with nursing staff to be completed by 12/23/08	

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I 500	Continued From page 15 #3's prescribed medication regimen included the psychotropic medication Abilify, 15 mg every evening. b. At approximately 1:15 PM, review of Resident #1's POs revealed similar findings (August and November 2008, "good for 90 days"). Resident #1's regimen included Prozac and Buspar. At approximately 4:25 PM, interview with the facility's RN and the Qualified Mental Retardation Professional revealed that they had both seen a May 2008 notification letter that was sent to every licensed residential facility from the Health Regulation Administration reminding them of the requirement to set a termination date not to exceed 30 days for all prescribed psychotropic medications. They showed where the previous primary care physician (PCP) had issued monthly POs. Moments later, they indicated that the facility had not informed the new PCP (effective August 2008) of this requirement. 3. The facility failed to demonstrate protection of residents' rights to receive prompt and adequate medical attention. [Title 7, Chapter 13, § 7-1305.05(g), formerly § 6-1965(g)] as follows: Cross-refer to I374. Resident #3 reportedly sustained a self-inflicted cut, bruising and swelling to his right eye area on September 17, 2008. Staff reported that the injuries occurred during the morning van run, at approximately 7:45 AM. Later that day, at 4:10 PM, a residential LPN documented "swelling... with small cut" in a progress note. The facility's RN then entered an 11:00 PM progress note, documenting that he had assessed the resident upon return from the hospital ER. [Note: Review of the September 17, 2008 incident report revealed no documented	I 500	The Physician Medication Order was discussed with the Primary Care Physician and the Psychiatrist. It was agreed that the Psychiatry Medication will carried a separate order which will be for 30 days. All other medication will continued to be for a 90 day period. In the future all Psychiatry Medication will carry a 30 days order. It is the policy of St John's Community Services to protect all rights of the individuals in its care. All staffs will be trained on policy and procedure on Medical emergency on 12/23/08.	

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I 500	Continued From page 16 evidence that the RN was notified of the injury.] On November 25, 2008, at 4:25 PM, interview with the RN revealed that he had directed staff to take Resident #3 to the ER shortly after 5:00 PM on September 17, 2008, once he learned that the resident had sustained head injuries. He further stated that "If anyone hits their head and there's an injury, we take <the individual> to the ER... That's what we have do... don't know if it's a written policy." According to the September 17, 2008 incident report, the day program nurse "gave a note about the incident. Staff brought the note home and called the house manager and informed him about it." There was no documented evidence, however, that Resident #3 received timely medical evaluation. Specifically, he spent much of the day at his day program and was taken to an emergency room only after the residential RN learned of the injuries that evening. [Note: The hospital discharge papers indicated that he had "a head injury which does not appear serious at this time..." The discharge papers did not, however, indicate what diagnostic procedures were utilized during the ER evaluation.]	I 500	Staff training for nursing and house staff that addresses policy and procedure of when to take an individual to ER to be completed by 12/23/08	
I 999	FINAL OBSERVATIONS The following observations were made during the survey process. It is recommended that these areas be reviewed and a determination made regarding appropriate action to prevent potential non-compliant practices: 1. Interview with the Program Coordinator/Qualified Mental Retardation Professional (QMRP) on 11/25/08 at 12:15 PM	I 999		

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I 999	Continued From page 17 revealed that Resident #1 had an increase in his targeted behaviors beginning in 8/08, which was of an undetermined origin. The review of behavior data reflected that in 8/08 Resident #1's targeted behaviors (self-injurious behavior, physical aggression, property destruction, and screaming) had more than doubled. From 9/08 to 10/08, property destruction increased (from 3 to 20 incidents) and screaming increased (from 15 to 82 incidents). The review of the physician's orders on 11/25/08 at 2:40 PM revealed a new medication, Buspar 10 mg TID was introduced on 9/15/08. Interview with the QMRP and the record review 11/25/08 at 4:27 PM indicated that the new medication and the increase had been approved by the Human Rights Committee (HRC). Further interview with the program coordinator and with the RN revealed the GHMRP had been unable to ascertain the cause of the increase in the resident's maladaptive behaviors. A medical note dated 11/21/08 reflected that the primary care physician recommended a psychiatric evaluation to determine a possible cause of the significant increase in the resident's behavior. Interview with the RN indicated that the psychiatric appointment needed to be scheduled. 2. The GHMRP failed to ensure that Resident #1 received a timely psychological reassessment. Interview with the QMRP on 11/25/08 at 11:32 AM revealed that Resident #1 was in a community based waiver home. Subsequent review of the clinical record indicated that waiver services had been approved for day placement, residential habilitation, occupational therapy and	I 999	The increase in the Buspar was discussed during the Human Rights Committee Review. However repeated request for a copy of the minutes did not yield the report timely. This request has been address further with the Chairman of the HRC with emphasis placed on timely submission of the meeting minutes for review of all monitoring entities. In the future a copy of all HRC Minutes will be filed in the home in a timely manner. Psychiatry Eval to be scheduled on 12/18/08	

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I 999	Continued From page 18 physical therapy, speech and hearing. Additional record review revealed the resident had an expired behavior support plan (BSP) dated 9/4/07. At 5:50 PM, the QMRP acknowledged that there had been a delay in securing an updated assessment and BSP. However, she indicated that waiver psychological services had recently been approved for Resident #1. Additionally, the QMRP indicated that the psychologist would be scheduled to conduct a comprehensive assessment for the development of an updated BSP. At the time of the survey, there was no evidence the resident was receiving psychological services in accordance with his needs.	I 999	A copy of the BSP for Resident #1 is attached for your review.	